



Ombudsman's Commentary

OCTOBER 2007 REPORTS

I laid 32 investigation reports before the Scottish Parliament today. Fourteen relate to the local government sector, 13 to the health sector, two to the Scottish Government and devolved administration, two to further and higher education and one to a housing association.

Details of the reports are summarised below and the full reports are available on the SPSO website at www.spsso.org.uk/reports/index.php

Ombudsman's Overview

In this month's Overview, I wish to focus on the Opinion about **Free Personal Care** (FPC) that was issued last week by Lord Macphail. The Opinion was on an application by Argyll and Bute Council for Judicial Review of a decision of an SPSO investigation report into a complaint that the Council had not provided funding for the personal care of an elderly man. This was the SPSO's first judicial review and the Opinion can be found at: www.scotcourts.gov.uk/opinions/2007csoh168.html.

In the report in question (Case ref 200503650, laid in November 2006) I concluded that there was a statutory duty placed on the Council by the Community Care and Health (Scotland) Act 2002 to make funding available for his already assessed personal care needs from the time the service was being provided. I therefore upheld the complaint and recommended that the Council make payments for FPC from the date on which the elderly man received the services he had been assessed as needing.

In his Opinion, Lord Macphail states that he has 'with reluctance' reached the conclusion that my decision in determining that there was a statutory duty placed on the Council by the CCHSA was incorrect. He recognises the implications of his Opinion, stating:

"I am acutely aware that my decision means that since the coming into effect of the new regime on 1 July 2002 there has been a widespread misapprehension as to the meaning and effect of the legislation on the part not only of local authorities but also of the Scottish Executive and of persons over 65 in private care homes and their families." (Para 70)

I am pleased that Lord Macphail recognises the important role of an Ombudsman. In Para 19, for example, he quotes from Wade and Forsyth, *Administrative Law* (9th edn):

"[The Ombudsman's] effectiveness derives entirely from his power to focus public and parliamentary attention upon citizens' grievances." In Para 103 he writes:

"If the Ombudsman's decision was correct, an issue remained about the adequacy and the method of funding of the policy of free personal care. If her decision was wrong, a wider issue still remained: that CCHSA had failed to capture the policy objective of providing personal care services to all those assessed as needing them, regardless of their means and free of any charge. In either case, difficulties had plainly arisen in the implementation and delivery of that policy. The Ombudsman's role in that connection was not to pronounce definitively on what the law was, or on what the solution should be. Her role, once her investigative jurisdiction was engaged by a complaint, was to inquire into the matter and to report in such a way that the nature of those difficulties – the systemic problems exposed by the complaint – were properly identified and canvassed, so that resolution of those difficulties might be pursued through ordinary political processes."

As I have frequently stated, it is not for the Ombudsman to determine law or set policy. Our task is to consider complaints brought to us by, or on behalf of, members of the public who claim 'hardship or injustice' as a result of maladministration or service failure by organisations charged with providing public services in Scotland. Where we identify problems in the implementation and delivery of policy, we draw these to the attention of the appropriate bodies.

I have welcomed the Scottish Government's review of the FPC policy, and I believe that Lord Macphail's Opinion reinforces the urgency of the review. In addition, we are participating in a Consortium of Interest established by the Confederation of Scottish Local Authorities which aims to obtain clarity regarding the legislative requirements placed on local authorities and other providers.

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One of the reports I lay today is about a related issue, namely **NHS Continuing Care Funding** (Case ref 200602124).

The complainant complained that her mother, Mrs A, who suffers from Alzheimer's, had been wrongly charged for her care in her nursing home. I identified, as I have in previous investigations (Case refs 200500976, 200502634, 200501504), issues concerning the clarity, accessibility and transparency of the process for assessing eligibility for NHS-funded Continuing Care. I did not uphold the complaint that Mrs A was unreasonably refused funding because I did not consider that the Board could be held responsible for a lack of provision in the legislation, as this can only be addressed by the Scottish Government. I state:

"The concern and belief that unremedied injustice exists is raised in a number of the complaints about Continuing Care brought to this office. This continues to cause distress and anxiety for vulnerable individuals and their families and to take up a considerable amount of NHS time and resources in addressing these. This office will, in turn, continue to receive complaints which we are unable to determine."

In an Annex to the report, I highlight procedural difficulties and confusion arising from the guidance (MEL 1996 (22)).

"This and other complaints to the Ombudsman indicated an urgent need to review the guidance on NHS Continuing Care Funding which was issued more than 11 years ago. This is not a matter which an individual Health Board is able to address so cannot be resolved within this report. The Ombudsman has previously drawn this matter to the attention of the (then) Scottish Executive Health Department and has now been informed that a review of this policy is underway with the intention that it will report in January 2008. In light of this action this office has formally suspended consideration of any further complaints raised with us on this matter pending the outcome of the review by the Scottish Government Health Directorates."

I am also highlighting two themes that frequently recur in reports about the health sector. The first relates to decisions made inappropriately by GP Practices to **remove a patient from a practice list** and the second to **poor record-keeping**.

I upheld a complaint (Case ref 200501825) that the decision by a GP Practice to remove a patient and his family from its list was wrongly taken, as the Practice did not follow its own guidance in this regard and no warning was given, as is required by law. I, therefore, recommended that the Practice apologise in writing to the complainant and his brother and father for the failures identified in my report and that it review how it takes decisions to remove patients from its list in light of The National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004, and ensure that its policy and actions comply with these regulations.

As I have stated before, appropriate record-keeping is not an optional extra, a 'nice-to-have', but is essential for good patient care. One report, for example (Case ref 200601149), while acknowledging that the Board has now taken steps to improve their record-keeping, states:

"I am unable to conclude with any certainty on whether Mr C's fracture should have been detected prior to his discharge or whether staff in another hospital failed to react appropriately and speedily to his readmission and his subsequent deterioration. I cannot do this because of a lack of records."

Another report (Case ref 200600121) states:

"It is important to keep good and accurate records so that any other healthcare professional who sees the patient later can see what has been happening and – importantly – why. In relation to examinations done or the results of tests, it is important to record negative findings as well as positive. So, for example, if an examination that would normally be expected is not carried out, that fact, and the reason, should be recorded. Likewise, if a doctor takes a patient's blood pressure, and it shows a normal reading, that should be recorded, despite being normal, to show that it was done. Healthcare professionals often say they do not have time to write down everything. It is not necessary to write down everything – simply to record enough to show what was done or (where appropriate) not done and why. This can benefit not just patients but also healthcare professionals in helping them to respond to, and defend themselves against, complaints and claims of negligence. Often, accurate, legible and complete records are the only defence in such cases. We were pleased to note the positive stand taken on this in a recent edition of the magazine produced by the Medical and Dental Defence Union of Scotland for their members."

From local government complaints I would like to underscore the need for councils to ensure that they properly advise tenants of possible changes to their **Right to Buy** discount that may arise from any new tenancy. A report laid today (Case ref 200600696) concerned the loss of a woman's Right to Buy discount after she moved house on Police and social work advice, having been assured that her discount would remain unchanged. I found that the complainant was not advised of the effects of the move on her discount before the creation of her new tenancy and, therefore, concluded that insufficient time was given to allow proper consideration of the implications of the change of tenancy on her Right to Buy. I recommended that should the complainant wish to proceed with the sale of her house, she should be able to do so on terms equivalent to those which would have applied had she retained her Right to Buy discount. I further recommended that the Council take steps to ensure that a process is put in place to provide tenants with written advice, in advance of any new tenancy, of possible changes to their Right to Buy discount.

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Health

Clinical treatment, communication

Tayside NHS Board (200600121)

I upheld Miss C's complaint that the care of her late uncle, Mr A, in hospital during the festive period fell below a reasonable standard. Mr A was receiving treatment for a chronic lung disease. Miss C's concerns centred around a delay in review by a senior doctor, delays in treatment when her uncle's condition deteriorated and a lack of communication with the family. I made a number of recommendations to the Board, including that they put in place a policy, protocol or guidance in relation to infective exacerbations of chronic lung disease, and that they provide evidence of the systems in place to monitor and audit nursing records.

Care of the elderly: clinical treatment, hospital discharge, record-keeping, complaint-handling

Lothian NHS Board (200601149)

I upheld the complaint made by Mrs C that her late husband was prematurely discharged from hospital, that the Board subsequently failed to provide him with appropriate and timely care and treatment and that the Board failed to make an adequate response to Mrs C's complaint, due to missing medical records. I have commented in my Overview about the inadequacy of the record-keeping. I made several recommendations to the Board to address the failings identified.

Complaint handling

Greater Glasgow and Clyde NHS Board (200500388)

The complainant, Ms C, raised a number of concerns about how her complaint about the conduct and behaviour of hospital staff was dealt with by the Board. I upheld the complaint.

I made a number of recommendations to the Board with regard to improving their complaint handling system, especially in relation to putting in place arrangements to handle complaints where serious allegations are made by a patient about a member of staff. I also recommended that the Board make Ms C a full formal apology, in accordance with my guidance note on 'apology'.

Treatment and care, waiting times for appointment

Greater Glasgow and Clyde NHS Board (200500921)

A 71-year old man, Mr C, complained about the length of time he had been advised he would have to wait to see a neurologist within the former Argyll and Clyde NHS Board (now Greater Glasgow and Clyde NHS Board), after his GP had requested a routine referral. I upheld the complaint as no consideration appeared to have been given to implementing measures to help utilise clinic time more effectively, until the recruitment of additional staff. This was despite the fact that the Board themselves considered a two and a half year waiting list for a routine referral unacceptable. I further considered that the age of Mr C should also have been taken into account, due to the length of the waiting list. As such, I recommended that the Board formally consider age as one of several factors when a patient is referred to a waiting list which is unavoidably long.

Clinical treatment, communication

Lothian NHS Board (200601624)

The complainant, Mr C, raised a number of concerns about the podiatry treatment he received while he was recovering from a stroke. I upheld one aspect of the complaint in that staff at the hospital did not take into account his speech and mobility problems before giving him treatment, and pain relief was not discussed with him, resulting in him suffering extreme discomfort. In light of my findings, I recommended that for stroke patients, like Mr C, who are receiving podiatry treatment, the Board discuss, and record, the situation with regard to pain relief. I did not uphold the aspect of the complaint that pain relief was not offered at the local podiatry clinic.

Diagnosis, removal from practice list

A GP Practice in Greater Glasgow and Clyde NHS Board (200501825)

I did not uphold Mr C's complaint that the GP Practice failed to diagnose and treat his illness, as I determined that although the practice doctors did not diagnose the specific illness, they acted appropriately on the basis of presenting symptoms. However, I did uphold Mr C's complaint that the decision by the Practice to subsequently remove him

and his family from its list was wrongly taken, and I have commented on this in my Overview above.

Clinical treatment, hospital discharge

Lothian NHS Board (200500768)

I upheld two aspects of Mrs C's complaint about the care and treatment she received, in that there was a failure by nursing staff to provide adequate post-operative nursing care and that Mrs C was not discharged from hospital within a reasonable time. I made a number of recommendations to the Board to redress the failings identified and ensure that they do not recur.

Clinical treatment

Greater Glasgow and Clyde NHS Board (200502714)

I upheld one aspect of Ms C's complaint about her consultant: that she wrote a letter to Ms C's GP containing information that Ms C had advised was incorrect. As the consultant has apologised to Ms C and clarified the information in her first letter with a second letter to the GP, I have no recommendation to make as the appropriate action has already been taken.

I did not uphold five other complaints in the health sector about the following issues and bodies:

Clinical treatment

Grampian NHS Board (200600187)

NHS-funded Continuing Care

Lothian NHS Board (200602124)

Diagnosis

Tayside NHS Board and a GP Practice in the Board Area (200602833, 200603448)

Clinical treatment

Greater Glasgow and Clyde NHS Board and a GP Practice in the Board Area (200501444 & 200502544)

Diagnosis, clinical treatment

A GP Practice, Forth Valley NHS Board (200500980)

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Local government

Housing: Right to Buy Angus Council (200600696)

This case is summarised in my Overview above.

Roads and Transport: policy / administration Argyll and Bute Council (200601959)

I upheld the complaint by Mr C about the way the Council had consulted on a proposed Traffic Order which restricted waiting and loading on the street where he lived. I concluded that the Council had restricted the opportunities for Mr C to find out about the proposed Traffic Order by the way they gave notice of the proposals. Therefore, Mr C was given less opportunity to raise his concerns about the way the proposals affected his street. I recommended that the Council apologise to Mr C for the shortcomings identified and that a review be undertaken of the way proposed Traffic Orders are notified to reflect the concerns raised in my report, giving particular attention to the wording of advertisements and the notification of residents considered likely to be affected by proposed changes. I note that the Council have already informed Mr C that they were considering placing all traffic regulation orders on their website and I commend them for this initiative.

Roads and Transport: claims for compensation, complaint handling

The City of Edinburgh Council (200601406)

I upheld Ms C's complaint that the Council did not correctly handle her claim for compensation for damage to her car following a journey around Edinburgh and that the Council also did not appropriately respond to her concerns about road maintenance. I found that there were delays in dealing with Ms C's claim for compensation, that there was a lack of clarity in the way that her complaint was handled and

progressed and also that there was inadequate and incorrect information provided in response to her request for information about the Ombudsman. I have previously made recommendations to the Council about their complaint handling and delays in responding to correspondence in report numbers 200503141 and 200501259, which have been accepted. I further recommended that the Council ask their claim-handlers to reconsider Ms C's claim; that they ensure all organisations working on their behalf are aware of the complaints procedure and the role of the Ombudsman; that they review actions taken in response to previous reports and ensure that they cover the problems identified in this report, or take appropriate action to do so, and finally, that the Council apologise to Ms C for the delays in processing her claim and for the complaint handling faults identified in my report.

Burial grounds Midlothian Council (200603409)

I upheld the complaint made by Ms C that the Council failed to give advance notification of the fact that her family's three-interment lair might only be able to hold two interments, although I did acknowledge that Council staff made every effort to prepare the lair so that it would be appropriate for three interments. I recommended that the Council review their procedural documentation, and include in it guidance to staff on what action should be taken should lairs be found to be unsuitable for their intended number of interments upon opening, whatever the reason for the problem. The Council have accepted my recommendation and I also commend them for taking action to resolve this matter to Ms C's satisfaction.

Planning: Tree Preservation Orders The City of Edinburgh Council (200600977)

I upheld this complaint which raised a number of concerns about the tree preservation order protecting trees on the

land of the complainant, Mr C, and the Council's response, in relation to the site, to a Public Local Inquiry. I recommended that the Council apologise to Mr C for the failings identified in my report, mainly the provision of inaccurate information, and also remind staff of the importance of giving accurate information in response to enquiries from members of the public. I further recommended that the Council formally request the necessary information from Mr C on the trees to be felled so that their knowledge on the tree work is up-to-date and that they take steps to investigate how this error occurred and to ensure that officers are in possession of accurate information when responding to a Public Local Inquiry.

Handling of planning application, record-keeping Falkirk Council (200603413)

The complainants, the directors of a building company, complained about the way in which the Council handled their request for timber decking to be laid as a Non Material Variation to planning permission. I upheld their complaints that the Council failed to deal with their oral request for the decking to be considered as a Non Material Variation and that their formal application for the same failed to receive a timely response. I also partially upheld their complaint that the Council failed to hold proper file notes. I recommended that the Council apologise for their oversights and failure to deal with the application in a timely manner and I also recommended that the Council emphasise to staff the importance of acknowledging documentation sent to them and the importance of properly recording all the relevant details of meetings.

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Local government

Planning: unauthorised developments, calls for enforcement action, complaint handling

Loch Lomond and the Trossachs National Park Authority
(200502021, 200503294)

I did not uphold two aspects of the complaints made by Mr C and Mr D, namely that the Park Authority failed to take enforcement action in respect of the unauthorised development of a pathway and failed to stop a vehicle turning circle being used as a car park. However, I did recommend that the Park Authority formally notify the conservation charity that the pathway near to Mr C and Mr D's homes is unauthorised, explain to them in detail why this is the case, and advise that any future development undertaken by the charity within the National Park must go through the proper planning process, with this specific case used as an example. I requested that copies also be sent to Mr C, Mr D and myself. I did uphold the complaint handling aspect of the complaint and recommended that the Park Authority review their complaint handling procedures.

Handling of planning application, complaint handling

The City of Edinburgh Council
(200601887)

I upheld the complaint handling aspect of this complaint and recommended that the Council apologise to Ms C for failing to give a full response to her complaint and confirm that recent improvements to their complaint handling system address the issues highlighted in my report, which identifies the need for measures to ensure the appropriate handling of complaints that concern more than one department and checks on the quality and adequacy of responses to complaints.

Social work: hearing / committee procedure

South Lanarkshire Council
(200600504)

The complainant, Mrs C, raised a number of concerns about the way in which the Council handled a Social Work complaint she made involving her elderly mother. I upheld one aspect of her complaint in that the outcome of the Complaint Review Sub-committee hearing was unclear. I concluded that the complaints from Mrs C, which the Council had identified, were not individually addressed in the Hearing's report, nor was it recorded whether individual complaints had been upheld or not. I recommended that, in order to avoid doubt, when the Council report their findings with regard to Review Sub-Committee hearings, care is taken to ensure that each identified head of complaint is specifically addressed and responded to.

Building control: policy / administration, complaint handling

Renfrewshire Council
(200603161)

I partially upheld one aspect of this complaint in that the Council did not respond appropriately to Mrs C's concerns about lack of action following the serving of a defective building notice on a neighbouring property. I recommended that the Council reinforce in their guidance to staff that they should ensure the Council respond as a whole organisation to complaints when issues raised affect more than one department. Although I did not uphold the other aspects of Mrs C's complaint, I did recommend that the Council arrange regular reviews of the effectiveness of their policy on issuing and enforcing defective building notices and consider whether they should provide more information to members of the public about such notices and, in particular, what is likely to happen when a notice is issued.

Environmental cleansing, complaint handling

Perth and Kinross Council
(200604086)

I partially upheld one aspect of this complaint in that the Council mishandled Mr C's complaint about dog fouling in a public area adjacent to his property. I recommended that the Council continue to carry out appropriate surveillance of the area in question and that they review their complaint handling in this instance with a view to clarifying to complainants at the outset the distinction between a request for a service and a complaint of dissatisfaction about delivery of a service.

Housing applications, complaint handling

East Dunbartonshire Council
(200601420)

Mr C, a housing officer, complained about number of aspects of the Council's handling of Ms A's application for housing and raised concerns about the way her complaints had been handled and how the Council had dealt with Ms A's application for a Discretionary Housing Payment. I did not find that the Council mishandled Ms A's application for a Discretionary Housing Payment. However, I did partially uphold Mr C's complaint that the Council mishandled Ms A's application for housing, following her assessment as unintentionally homeless and fully upheld his complaint that the Council did not respond adequately to Ms A's concerns about this. I recommended that the Council apologise to Ms A for the failures in their complaint handling and to Mr C for their failure to respond to his letter. I also made recommendations concerning complaint handling, record-keeping and evidence of procedures to provide a clear record of the state of properties at the point of entry and also asked that staff involved in the award of discretionary social points are aware of the comments made in my report. The Council have accepted my recommendations and I also commend them for accepting that problems may have been caused by Ms A having several points of contact and seeking to resolve this before the matter came to my office.

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Local government

I did not uphold two other complaints in the local government sector about the following issues and bodies:

Handling of planning application

The City of Edinburgh Council (200501269)

Handling of planning application

Falkirk Council (200600453)

I did not uphold this complaint but I did recommend that the Council consider whether it could use powers contained in the Antisocial Behaviour etc Act 2004 to address the problems of vandalism, graffiti and antisocial behaviour which the complainant is experiencing.

Further and Higher Education

While I did not uphold either of the complaints about colleges, I made recommendations in both cases, relating to the clarity of information for students and prospective students.

Admissions

Dundee College (200501734)

Policy / administration

Aberdeen College of Further Education (200502939)

Housing Associations

Anti-social behaviour, complaint handling

Link Group Ltd (200501460)

The complainant, Mr C, raised two main issues: whether or not Housing Association staff informed a prospective tenant (Mr A) about anti-social behaviour problems; and, how the Association's parent organisation responded to the complaint. I made no finding on the alleged failure of the staff to inform Mr A about anti-social behaviour problems but I did partially uphold one aspect of the complaint relating to the investigation carried out by the Association, and I made a number of recommendations in this regard.

Scottish Government and devolved administration

Policy / administration

VisitScotland (200603492)

The complainants, Mr and Mrs C, raised a number of concerns about the way in which VisitScotland handled their complaint about the Quality Assurance Scheme. I partially upheld one aspect in that the standards that Mr and Mrs C required to achieve to increase their star grading were not sufficiently specified. I recommended that, in relation to their current standards, VisitScotland ensure that inspection staff are clear about the standards pertaining to each star rating and that, as far as possible, these standards are specific and measurable. I did not uphold the other two aspects of the complaint.

Policy / administration, complaint handling

Scottish Enterprise (200400906)

I did not uphold this complaint.

Compliance and Follow-up

In line with SPSO practice, my Office will follow up with the organisations to ensure that they implement the actions to which they have agreed.



Professor Alice Brown
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The compendium of reports can be found on our website, www.spsso.org.uk

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